Health Plan Enrollment Change Request

Instructions

Use this form to elect coverage for the following plans: Medical/Prescription Drug(Rx), Dental, and Vision. You may choose coverage for yourself and your eligible family members under the Medical/Prescription Drug(Rx), Dental, and Vision plans. **All applicable documentation must be submitted in order to process your request. Please retain a copy for your records. Submit this form directly to the appropriate Service Center.**

Employee Information (0001)

Date Form Prepared: _____ Prepared By: _____

Effective Change Date: _____ Employee Name: _____

Last Four Digits of SSN: _____ Employee Personnel Number: _____

Employee Telephone Number: _____ Hire Date: _____

Company Code: _____

Business Area: _____ (required for 0040, 0114, 0571, 0107, 0109, 0113, 0119, 1330, 0138, 0145, 0153, 0185, 0200, 0395)

Dental Coverage

◯ Qualified Change in Status (Coverage effective on the date of event).
◯ No Change

If a Qualified Change in Status has occurred, you must also complete the Family Information Section.

Reason for qualified change in status: _____ Date of Event: _____
(See last page for applicable reason codes)

◯ CSC Dental Plan
◯ CSC Dental Plan Plus
◯ Cigna International Expatriates Benefit Dental Plan

Note: Cigna International Expatriates Benefit Dental Plan is applicable only for U.S. based employees assigned overseas for 90 or more days.

◯ 1: Waive
◯ 2: Employee Only
◯ 3: Employee + 1 Dependent
◯ 4: Employee + Family

Medical/Prescription Drug (Rx) Coverage

◯ Qualified Change in Status (Coverage effective on the date of event).
◯ No Change

If a Qualified Change in Status has occurred, you must also complete the Family Information Section.

Reason for qualified change in status: _____ Date of Event: _____
(See last page for applicable reason codes)

◯ BC/BS PPO of Alabama
◯ CSC EPO Plan
◯ CSC Preferred Access
◯ HMO
◯ TRICARE Supplement
◯ Cigna International Expatriates Benefit Medical Plan

Note: BC/BS PPO of Alabama is applicable for employees that live or work in Alabama only. PPO enrollment form also required to complete enrollment in this plan.

Note: Only individuals covered by U.S. military TRICARE plan may elect the TRICARE Supplement coverage, in lieu of other CSC medical coverage. TRICARE Supplement enrollment form also required to complete enrollment in this plan.

Note: Cigna International Expatriates Benefit Medical Plan is applicable only for U.S. based employees assigned overseas for 90 or more days.

A separate HMO Enrollment form must be completed for HMO plans.

HMO Name: _____

Employee's Home Zip Code _____

◯ 1: Waive ◯ 3: Employee + 1 Dependent
◯ 2: Employee Only ◯ 4: Employee + Family

Note: Pre-existing conditions are subject to the limitations of each plan. However, prior medical coverage may be used to offset pre-existing conditions limitations under CSC medical plans. The Service Center Help Desk can provide you with additional information.

Vision Coverage

◯ Qualified Change in Status (Coverage effective on the date of event).
◯ No Change

If a Qualified Change in Status has occurred, you must also complete the Family Information Section.

Reason for qualified change in status: _____ Date of Event: _____
(See last page for applicable reason codes)

◯ Cigna International Expatriates Benefit Vision Plan
◯ CSC Vision Plan

Note: Cigna International Expatriates Benefit Vision Plan is applicable only for U.S. based employees assigned overseas for 90 or more days.

◯ 1: Waive
◯ 2: Employee Only
◯ 3: Employee + 1 Dependent
◯ 4: Employee + Family

Family Information

Instructions: Please provide the following information for all eligible family members (see last page for definitions) who are to be covered by CSC health care plans (CSC Medical/Prescription Drug(Rx), Dental, and Vision).

Are you adding or dropping a dependent? ◯ Yes ◯ No

If Yes, you may want to consider changing your beneficiary. If you do, please complete the **Designation of Beneficiary Form.**

If Yes, and you do not provide the required Family Information, claims will be denied.

I choose to activate (A) or inactivate (I) Medical/Prescription Drug(Rx), Dental, and Vision coverages, for my eligible family member(s) indicated below.

A/I	Coverage *	Last Name	Suffix	First Name	Birth Date	Relationship **	Gender
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male
_______	◯ D ◯ M/Rx ◯ V	__________________	____	________________	___/___/___	___________	◯ Female ◯ Male

* **Coverages:** M/Rx= Medical/Prescription Drugs D=Dental V= Vision

** **Relationship:** W=Wife H=Husband D=Daughter S=Son L=Legal Guardianship

Sponsor of other benefits (e.g., spouse's employer): ____

Other benefits payable through (check one):

◯ HMO
◯ Insurance Company (e.g. Prudential or BC/BS)
◯ Medicare/TRICARE
◯ Medicaid
◯ Other

If "Other", please specify the name(s): __________________________________

I understand that only my eligible family members may be covered by CSC's benefit plans and certify that the named individuals qualify as dependents as defined above and that all information provided is true and correct. I also understand that I can make changes only when there is a qualified change in family status or during the next annual enrollment period, and that I may submit claims only for those family members that I have enrolled. I also understand that a pre-existing conditions exclusion may apply when enrollment occurs. (See last page for additional information.)

Employee's signature: ____________________ Date: ____/____/____

Health Plan Enrollment Authorization

Authorization for Contributions

I understand that any employee-required contributions toward any health-care coverage (Medical/Prescription Drug(Rx), Dental, and Vision plans) available through CSC will be taken on a **pre-tax** salary basis. This will apply to all federal and state taxes as allowed by law. According to federal law, this pre-tax contribution selection is binding until the next annual enrollment period unless a change in status (marriage, divorce, etc.) occurs. I understand by doing this, deductions for federal and state taxes, Social Security and State Disability Insurance (if applicable) will be reduced. I also understand that any benefits that I may become entitled to from Social Security, State Disability and State Unemployment may also be minimally reduced, as a result of this selection.

I authorize Computer Sciences Corporation to take deductions from my salary for contributions required (if any) for coverage as indicated above.

Employee's Signature: _____ Date: ____/_____/_____

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Family Status Changes

I. Section 125 of the Internal Revenue Code allows you to change your coverage (CSC health care and supplemental life/AD&D plans) during the plan year for the reasons listed below. Enter the appropriate alphabetical code on the front of this form that best describes your reason for change in status. Enter the effective date of the change in status.

Code	Family Status Change Reason	Required Documentation
A	Marriage, divorce, legal separation or annulment	Marriage Certificate, Legal Separation Court Documentation, or Divorce decree
B	Birth or adoption of your child (or placement of a child for adoption in your home)	Birth certification, proof of adoption or placement for adoption, or legal documentation for foster care.
C	Death of a spouse or dependent child	Death Certificate
D	Change in work schedule as a result of the following: ● A reduction or increase in hours ● Full-time/part-time switch ● Beginning or ending of an unpaid leave of absence. ● Strike or lockout of yourself or spouse	Certificate of Creditable coverage or a letter from the spouse's employer showing the date of termination of coverage in order to add dependents. Documentation from the spouse's employer indicating that the spouse is covered under the employer's plan. Documentation must indicate the date coverage commenced
E	Commencement/Termination of coverage due to a change in yours, your spouse's or your dependent's employment status.	Documentation from the spouse's employer indicating a significant change in the spouse coverage or cost of coverage
F	Your dependent child is no longer eligible, or became eligible, due to change in student status, attainment of limiting age or getting married	If adding - verification of full-time student status. If deleting - no documentation.
G	Change in work site	Call CSC Service Center at (703) 318-2800 or 1-877-612-2211 for required documentation.
H	Change in residence of you, your spouse or dependent that results in eligibility or loss of eligibility	Call CSC Service Center at (703) 318-2800 or 1-877-612-2211 for required documentation.
I	Termination or commencement of employment	Call CSC Service Center at (703) 318-2800 or 1-877-612-2211 for required documentation.
J	Other	Call CSC Service Center at (703) 318-2800 or 1-877-612-2211 for required documentation.

II. Omnibus Budget Reconciliation Act (OBRA) allows you to add dependent children when coverage is required under Qualified Medical Child Support Orders (QMCSO).

III. You may also change plans (but not family status) if you move out of or into an HMO service area.

IV. If 'J. Other' is selected you are required to provide documentation along with this request.

Elections due to changes in status and/or QMCSO must be because of, and consistent with, the changed status and must be made within 30 days of the effective date of the status change. Changes requested after the 30 days will not be implemented. The next opportunity you will have to change you current elections will be during the next annual enrollment for an effective date of January 1.

CSC is requiring the completion of this form to comply with the Health Insurance Portability and Accountability Action of 1996.